



# MedHealth Review, Inc.

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**DATE OF REVIEW:** 6/18/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include physical therapy to the right shoulder (12 visits).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has greater than 10 years of experience in this field.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination in all its parts.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties and (FOL) and Dr.

These records consist of the following: 6/3/09 letter from, 4/24/09 denial letter, 5/11/09 denial letter, 2/16/09 preauth request, 2/11/09 to 4/22/09 PT progress reports, PT script of 2/9/09, 4/12/09 PT request form, 4/8/09 script, 3/24/09 script,

daily notes by PT from 3/25/09 to 4/22/09, initial eval of 3/25/09 by MD, 5/4/09 PT request form, 4/8/09 note by Dr and 5/20/09 report by Dr.  
We did not receive a copy of the WC Network Treatment Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured when he fell and sustained a greater tuberosity fracture at the humerus. He has sensory abnormalities in digits III and IV. From Dr. note on 4/8/09, the reviewer infers that an EMG/NCS was done. This was consistent with abnormal median nerve conduction at the wrist bilaterally, delayed ulnar sensory responses and AIN syndrome. Whether or not the forearm and wrist fractures were clarified is not documented.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The reviewer notes that the ODG gives the following as recommended treatment plans for physical therapy:

- Fracture of humerus:           a) medical treatment 18 visits over 24 weeks  
  b) post-surgical treatment 24 visits over 24 weeks

The reviewer indicates that seven more treatments of PT are justified as per the records. However, twelve visits have been requested and this cannot be approved as per the Guides. Therefore, the requested service is denied at this time based upon the documentation provided.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**